State Initiatives to Advance Medical Homes for Medicaid and SCHIP Participants

(Initiatives that meet criteria for inclusion in analysis)

State	Program/Agency	Relationship to Medicaid or SCHIP	State authority	Federal authority	Funding/ Resources	Delivery System: (FFS, PCCM, MCO)	Start date	Population targeted/ #'s reached	Medical Home definition	Medical home provider types	Source
Alabama	Alabama Medicaid Agency: Patient 1st, a PCCM program (with shared cost savings with providers approved by CMS in 8/04) includes expanded technology and tools to help doctors and other health professionals better manage the increasing cost of health care while promoting better care for Medicaid patients. The state also obtained a transformation grant that will support practices in their efforts to serve as effective medical homes by creating a statewide, central, shared interoperable electronic health information system (HIS) that links Medicaid, state health agencies, providers, and private payers. The system will be in place by 3/08 and successfully utilized by Medicaid and at least one other HHS agency by 10/08.The pilot will be in place with documentation of improvement in selected measures of at least 4 percentage points from the baseline by 08/08, QI organization structure by 02/07, evidence based quality measures selected by 03/07, algorithms and tools created by 05/07 and 30% ECST (electronic clinical support tool) saturation by 06/07 (50% by end of second year).	Administered by Medicaid		1915(b) waiver for Patient 1st	Transformation Grant: FY 2007 $3.9m FY 2008 $3.7m	PCCM	The present Patient 1st program was approved by CMS in August 2004, transformation grant awarded in 2007, implemented in 2008.	448,708 Total Enrollees (All Medicaid beneficiaries except "SOBRA adults and dual eligibles") 84,247 Over 21 364,461 Under 21 * As of 4/20/06	Medical Home for eligible patients: ■Constant source of primary care ■Less reliance on Emergency Room care ■Coordination of referrals ■Case management by physician ■Specialized case management available when needed	Primary care physicians, including pediatricians, internists, family practice physicians and OB-GYNs, may enroll individually or with a group as a Patient 1st primary medical provider	http://www.medicaid.alabama.gov/
Arizona	Arizona Medicaid--The Arizona Health Care Cost Containment System (AHCCCS) included requirements related to medical homes in their last RFP for acute care services. They required all proposers to describe their system and plan to award a contract (and additional funding) to one MCO to assist in the development of a Medical Home for the Medicaid population. They are also working under a "Round two" CMS Medicaid Transformation grant to develop a ***Value Driven Decision Support Tool Box*** (The Tool Box) will be available to all 1 million plus Arizona Medicaid and SCHIP beneficiaries and the health plans and providers who serve them. This toolbox is intended, among other objectives, to better support medical home functions for both providers and beneficiaries.	Administered by Medicaid/SCHIP agency		1115 waiver for Medicaid program	Transformation Grant Round Two: $4.4 m	MCO	Contracts to begin October 2008, no date specified for work on 'model'	all Medicaid and KidCare (SCHIP) MCO enrollees, but special emphasis on those with special health care needs and chronic illness	The American Academy of Pediatrics (AAP) describes care from a medical home as: • Accessible • Continuous • Coordinated Family-centered • Comprehensive • Compassionate • Culturally effective	Health care providers designated by the Contractor as PCPs shall be licensed in Arizona as allopathic or osteopathic physicians who generally specialize in family practice, internal medicine, obstetrics, gynecology, or pediatrics; certified nurse practitioners or certified nurse midwives; or physician's assistants	Medical Home Summit application http://www.azahcccs.gov/eHealth/ http://www.azahcccs.gov/Contracting/BiddersLibrary/Acute/AcuteCareRFP_YH09-0001.pdf
California	California Medicaid (Medi-Cal) has two three-year disease management programs targeting seniors and persons with disabilities to test efficacy of disease management systems under FFS, will include linkage to a medical home. These programs are called the Coordinated Care Management Project (CCMP). Two RFPs were released--the one for seniors and persons with disabilities was released in May 2008. The one for people with serious mental illness in July 2008.	Administered by Medicaid	California Budget Act of 2006		Funding for these services may be limited to $12,150,000 for the entire contract term for each of the programs.	PCCM, FFS	October 2008 for seniors and persons with disabilities	a) seniors and persons with disabilities with chronic conditions and b) persons with chronic health conditions and serious mental illnesses			http://www.dhcs.ca.gov/provgovpart/rfa_rfp/Pages/OMCPccmp-spdHOME.aspx http://www.dhcs.ca.gov/provgovpart/rfa_rfp/Pages/OMCPccmp-smiHOME.aspx
Colorado	Department of Health Care Policy & Financing (HCPF), which administers the Medicaid and SCHIP programs is working with the Department of Public Health and Environment to implement 2007 legislation that requires the HCPF to maximize the number of children served by Medicaid or SCHIP who have a medical home. The Governor has a stated goal that "270,000 Medicaid and CHP+ children will have a medical home by 2010 with increased reimbursement to providers who meet medical home standards." Colorado is building on a pilot program to improve delivery of EPSDT services. Colorado is considering a variety of strategies for achieving its goals including enhanced reimbursement and the redesign of the EPSDT administrative case management program so that "medical home navigators" are situated throughout the state offering client education and supporting provider practices. Efforts are ongoing statewide to build infrastructure to support the increased use of health information technology (HIT) to improve the quality of health outcomes for all state residents.	Administered by Medicaid/SCHIP	■SB07-130 (2007) Medical Home for Children Legislation ■ SB07-211 Performance Measures for Medical Home		State budget authorized $335,698 for fiscal year 07/08 and $6,493,124 for fiscal year 08/09.	Mostly FFS but considering how to implement in MCO and PCCM	Standards have been approved by steering committee and efforts to implement them are underway Medical home navigators to be in place July 2009	Medicaid and SCHIP children	"Medical Home" means an appropriately qualified medical specialty, developmental, therapeutic, or mental health care practice that verifiably ensures continuous, accessible, and comprehensive access to and coordination of community-based medical care, mental health care, oral health care, and related services for a child. A medical home may also be referred to as a health care home. If a child's medical home is not a primarily medical care provider, the child must have a primary medical care provider to ensure that a child's primary medical care needs are appropriately addressed. All medical homes shall ensure, at a minimum, the following: (a) health maintenance and preventative care; (b) anticipatory guidance and health education;(c) acute and chronic illness care; (d) coordination of medications, specialists, and therapies; (e) provider participation in hospital care; and (f) twenty-four hour telephone care.	MCOs and certified providers that meet standards	Medical home summit application and follow-up survey Presentation at NASHP preconference http://www.healthcolorado.net/MedicalHome.shtml

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Colorado	The Colorado Clinical Guidelines Collaborative has convened a formal multi-payer pilot to implement medical homes for adults with chronic conditions in the Denver area. The 2-year pilot is due to be implemented in 2009. Ten to 15 practices are being selected through an application process. In order to apply practices must (1) be Family or Internal Medicine practices (2) be located on the Front Range (Ft. Collins to Colorado Springs), and (3) have >50% combined payer mix from the participating plans. Practices will sign an MOU and be required to achieve NCQA-PPC Level 1 status by April 2009. They will receive technical assistance and support, and be reimbursed under the PCPCC recommended three-tier model (fee-for-service, care management fee and pay for performance) Colorado Medicaid is participating in this effort.	Medicaid is participating in this effort, and is developing policies for its children's initiative that accommodate the goals of this pilot--such as deeming those practices that meet NCQA-PPC qualifications to meet those of the children's program.	Governor Ritter Executive Order established Center for Improving Value in Health Care (the Center's steering committee has prioritized medical homes)				2009	Adults with chronic conditions in the Denver area	PCPCC Joint Principles	Ten to 15 practices are being selected through an application process. In order to apply practices must (1) Be a Family or Internal Medicine practices (2) be located on the Front Range (Ft. Collins to Colorado Springs), and (3) have >50% combined payer mix from the plans participating in the pilot. Selected practices will sign an MOU and be required to achieve NCQA-PPC Level 1 status by April 2009.	http://www.coloradoguidelines.org/pcmh/default.asp
Connecticut	Medicaid: Developing a PCCM program to enhance the medical home concept. PCCM payment will be $7.50 per person per month. PCPs will be required, among other things, to, "hire case managers, to provide the resources and support needed for physician practices to better manage the care of enrollees" Also, Medicaid plans to provide utilization feedback to providers	Administered by Medicaid/SCHIP	Public Act No. 07-2, June Special Session	1915(b) waiver		PCCM	January 1, 2009	Medicaid managed care beneficiaries		Family medicine; General practitioner; Internist; A Primary Care Physician affiliated with a Federally qualified health center; Pediatrician; Osteopath; OBGYN; APRN (Consistent with state statutes); Nurse Midwife; Physician Assistant (Consistent with state statutes); A Specialist that may function as a PCP, per DSS approval.	Summit application http://www.ct.gov/dss/cwp/view.asp?Q=423906&A=2345
Florida	The legislature authorizes under the Medicaid Managed Care Pilot Project, the development of service delivery alternatives for chronic medical conditions that establish a patient-centered medical home to integrate the family, medical and developmental concerns. Requires two pilot projects to create a statewide initiative to provide for a more efficient and effective service delivery system that enhances quality of care and client outcomes in the Florida Medicaid program. The Children's Medical Services agency is leading this effort (still in pilot)	Directs Medicaid program to implement medical home project for CSHCN	Senate bill § 409.91211; 2008	1115 waiver		MCO	passed 2007	CSHCN, served by Children's Medical Network	A Medical Home Provides Care that is accessible, Family-centered, Continuous, Comprehensive, Coordinated, Compassionate, Culturally-competent (AAP definition)		http://www.leg.state.fl.us/statutes/index.cfm?mode=View%20Statutes&SubMenu=1&App_mode=Display_Statute&Search_String=409.91211&URL=CH0409/Sec91211.HTM http://www.nashp.org/Files/SloyerWood_NAHP2008.pdf
Georgia	Medicaid and SCHIP: Georgia Families (2007) Establish a medical home for members through use of selected/assigned Primary Care Providers (PCP) Georgia Families is a program that delivers health care services to members of Medicaid and PeachCare for Kids. The program is a partnership between the Department of Community Health and private care management organizations (CMOs). By providing a choice of health plans, Georgia Families allows members to select a health care plan that fits their needs.	Administered by Medicaid/SCHIP		Section 1932		MCO	2007	Children enrolled in PeachCare (SCHIP) and children, pregnant women and women with breast or cervical cancer on Medicaid are eligible to participate in Georgia Families.			survey response http://dch.georgia.gov/00/channel_title/0,2094,31446711_42524294,00.html
Hawaii	Medicaid: In 1993 Medicaid implemented a capitated managed care program and is now working to incorporate the ABD population. The Medicaid Program, (the Med-QUEST Division, (MQD)), will, under a Medicaid Transformation grant, design, develop and implement an electronic health record system targeting EPSDT eligibles (ages 0-20) and adult Aged, Blind, and Disabled who will be transitioned from the current Fee-For-Service (FFS) delivery system to Medicaid managed care. Improve care coordination through the medical home by enabling providers to identify and communicate their needs electronically through the web portal or through electronic interface to QUEST Care Coordinators and FFS contracted agencies. The hallmark of the EPSDT program is the Medical Home concept which is an approach to providing comprehensive primary care, it is logical to extend that infrastructure to support the ABD population.	Medicaid/SCHIP agency administers Med-QUEST and submitted the transformation grant application		1115 waiver	Transformation Grant Round Two: $1.8 m	MCO	Med-Quest started in 1993, now expanding to include ABD, transformation grant was awarded in 2007	All Medicaid beneficiaries who are children (under age 21) or qualify for Medicaid due to disability or age			http://www.cms.hhs.gov/MedicaidStWaivProgDemoPGI/downloads/Hawaii%20QUEST%20Fact%20Sheet.pdf http://www.cms.hhs.gov/MedicaidTransGrants/02_2007awards.asp#TopOfPage

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Idaho	Idaho's "Target for a Healthy Idaho" initiative will provide each person access to a medical home under the direction of a primary care provider. This state plans to concurrently address multiple system weaknesses, including its current shortage of primary care physicians and the supporting team of professionals. Idaho will focus first on technology to provide the foundation for patient-centered medical home. This aspect of the plan will be implemented in 2008. Two planning bodies have been formed to carry out this (and other) work. Idaho Health Quality Planning Commission is tasked with coordinating and implementing health information technology, including that envisioned to support medical homes, and the Select Committee on HealthCare is working to further develop the recommendations made as part of the Target for a Healthy Idaho. Also, two major commercial health plans are rolling out pilot medical home models.	Medicaid is a member of the Health Quality Planning Commission and of the Select Committee on HealthCare	Idaho Health Quality Planning Commission (technology) House Bill 738, 2006; EXECUTIVE ORDER NO. 2007-13 established Governor's Select Committee on HealthCare			FFS with some MCOs and primary case management	Pilot for the Health Data Exchange begins Fall 2008; medical home pilot dates undetermined at this time	All state citizens	Joint Principles		Summit application and follow-up survey
Idaho	Medicaid & SCHIP: require all appropriate participants to enroll in a medical home system called Healthy Connections. Medicaid pays medical home providers for identifying diabetic patients on a registry and provides enhanced payments for evidence-based procedures. "Idaho Medicaid has partnered with the Family Medicine Residency of Idaho and the Idaho Primary Care Association to develop a pay-for-performance pilot program focusing on managing chronic diseases. This program began by focusing on best practices in the care of diabetes, and will expand later to care of asthma, cardiovascular disease, and depression. The program uses recognized standard clinical criteria that reflects best clinical practices and will adjust reimbursement to reward these care practices. There are 326 Medicaid patients participating" Source: Medicaid Initiative Status Report, December 2006)	Medicaid/SCHIP agency administers program		DRA state plan amendment		PCCM, with MCO option for some dual eligibles	PCCM began in 1993, was moved to the state plan in 2007 and chronic care management was added in 2006				Summit application and follow-up survey http://www.healthandwelfare.idaho.gov/site/3629/default.aspx 2006 NATIONAL SUMMARY OF STATE MEDICAID MANAGED CARE PROGRAMS (by CMS)
Illinois	Illinois Health Connect is a PCCM program designed to advance medical homes. Providers receive a PMPM fee for PCCM activities that varies based on the member's eligibility category (e.g., family, ABD). Providers are given utilization feedback that will be tied to a pay for performance program. PCCM providers are supported in serving as medical homes by a disease management program.	Medicaid/SCHIP agency administer the program		section 1932		PCCM	July 2006	Mandatory HFS (Medicaid) enrollees: children in "All Kids Program", Parents in the "FamilyCare Program", Adults with Disabilities	"Your medical home is the doctor's office or clinic where you go to see your Primary Care Provider (PCP). Having a medical home means: All your medical records are kept there in one place Your primary care provider gets to know you well You get better health care because your personal doctor knows all of your health care needs You and your family get the top quality health care you need to stay healthy	General Practitioners, Internists, Pediatricians, Family Practitioners, OB/GYNs, Osteopaths and other specialists, Federally Qualified Health Centers (FQHCs), Rural Health Clinics (RHCs), Other clinics including certain specified hospitals, Certified local health departments, School-Based/Linked clinics, In certain instances, nurse practitioners, midwives, physicians assistants and advanced practice nurses may participate., Other qualified health professional as determined by HFS.	2006 NATIONAL SUMMARY OF STATE MEDICAID MANAGED CARE PROGRAMS (by CMS) Presentation on NASHP medical home webcast http://www.hfs.illinois.gov/managedcare/ http://www.illinoishealthconnect.com/
Iowa	Public Health: In 2008, the Iowa legislature passed the Health Care Reform Act, making a commitment to promoting and providing health care coverage for ALL Iowans. Based on recommendations developed as a component of previously directed legislative directed work groups and proposals from the governor and lieutenant governor, the legislature created House File 2539. The Bill charges the Iowa Dept of Public Health with developing a Medical Home Advisory Council to develop recommendations regarding a plan for implementation of a statewide patient-centered medical home system. The stated purpose of a patient-centered medical home is to provide for the coordination and integration of care, focused on prevention, wellness, and chronic care management, using a whole person orientation through a provider-directed medical practice. Implementation will occur in three phases. The initial phase will focus on providing a patient-centered medical home for children eligible for Medicaid. The second phase will focus on providing a patient centered medical home to adults covered by the IowaCare Program and to adults eligible for Medicaid. The third phase will focus on providing a patient centered medical home	The Director of Human Services, which oversees the Medicaid and SCHIP programs, is represented on the Advisory Committee and the Legislature directs the program to be implemented for Medicaid beneficiaries in the first phase	IDPH: Health Care Reform bill: House File 2539 (2008)		$165,600 for up to 4 FTEs	FFS, MCO, PCCM	Annual reports required	IDPH: Initially Medicaid-eligible children, then adults covered by IowaCare Program and Medicaid-eligible adults, and finally privately insured and self-insured adults as well as children covered by SCHIP (hawk-i) and children in need of a dental home	Medical home" means a team approach to providing health care that originates in a primary care setting; fosters a partnership among the patient, the personal provider, and other health care professionals, and where appropriate, the patient's family; utilizes the partnership to access all medical and nonmedical health related services needed by the patient and the patient's family to achieve maximum health potential; maintains a centralized, comprehensive record of all health related services to promote continuity of care; and has all of the characteristics specified in section 135.158. The legislation further defines the purpose of the medical home using the language of the PCPCC's joint principles except modifying the word 'physician' to 'provider'. (Source: House File 2539)		Summit application http://coolice.legis.state.ia.us/Cool-ICE/default.asp?Category=billinfo&Service=Billbook&menu=false&ga=82&hbill=HF2539

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Kansas	Medicaid, SCHIP, State employee coverage: Kansas Health Policy Authority (KHPA): By February 1, 2009, will develop systems and standards for implementation and administration of a medical home in Kansas. In the next phase of implementation, those primary care practices demonstrating key medical home characteristics will receive enhanced reimbursement when providing care to the target populations. KHPA also piloting the Community Health Record (web-based application populated with claims data for Medicaid enrollees) in 20 safety net practices.	Medicaid/SCHIP agency is administering program	SB 81 (new section 13) (2008)			MCO, PCCM	February 1, 2009	Medicaid and State Employee Health Benefit programs	''medical home'' means a health care delivery model in which a patient establishes an ongoing relationship with a physician or other personal care provider in a physician-directed team, to provide comprehensive, accessible and continuous evidence-based primary and preventive care, and to coordinate the patient's health care needs across the health care system in order to improve quality and health outcomes in a cost effective manner.		http://www.kslegislature.org/bills/2008/81.pdf
Louisiana	Medicaid (Department of Health & Hospitals) plans to develop Provider Service Networks (PSNs) as a "Medical Home System of Care" - "an organized health system operated by health system/providers offering an integrated (i.e. medical home) system of care to Medicaid beneficiaries and substantially owned by a hospital, physician group or consortium of the aforementioned." It is also participating in the Louisiana Health Care Quality Forum, a multi-stakeholder quality improvement collaborative, which endorsed the Joint Principles of a Patient Centered Medical Home and NCQA Guidelines for a Medical Home in March 2008	Medicaid/SCHIP agency is developing program	■Louisiana Acts 2006, 17 established program to enroll 80% of Medicaid eligible in Primary Care Case Management programs, providing a medical home and continuity of care ■Louisiana Acts 2007, 243 Directs DOH to develop and implement a system of medical homes for all residents who receive Medicaid or are low-income uninsured. The system must include the use of HIT.		Medicaid agency budget includes $4.7 million for the PSN pilot, $3 million for Disease Management, $3.5 million for EMR/LaHIE P4P and $2.4 million for LaRHIX (rural EMR initiative)	PCCM, but planning to go to PSN	Plan to pilot PSN in January 2010	The primary target population for DHH will be current Medicaid eligibles, with consideration of options to reach persons with higher income levels and coverage of the uninsured. The Quality Forum is working statewide with public and private providers	ACT No. 243: "Medical home system of care" shall mean a health care delivery system that is patient and family centered and is guided by a personal primary care provider who coordinates and facilitates preventive and primary care that improves patient outcomes in the most cost-efficient manner possible. By providing a coordinated continuum of care, the cost of the current health care delivery system shall be reduced, health outcomes shall improve, and the disparities in access to health care among the state's populations shall be reduced.	Joint Principles	Summit application
Maine	Medicaid participating in Multi-stakeholder effort to develop, implement and evaluate a Maine Multi-payer Pilot of the Patient Centered Medical Home. Plan to secure funding to launch 3-year pilot in early 2009. (Note, state already has a PCCM program.)	Medicaid agency is participating in multi-payer pilot	Maine legislature convened a Commission to Study Primary Care in 2007 which recommended multi-payer pilot and increased MaineCare funding; recommendations endorsed in January 2008 legislative resolve.			PCCM	early 2009	■MaineCare: PCCM for all but ABD enrollees; working to enroll 15,000 of highest cost enrollees with medical homes	Joint Principles		Summit application
Massachusetts	In 2008, Massachusetts enacted a law authorizing MassHealth (Medicaid) to develop a medical home pilot, including reforms to reimbursement and support for practices. It also created a commission on the health care payment system that will, among other things, investigate the medical home model. The commissioner of health care finance and policy is co-chair of this committee. MassHealth reported they are initially targeting the development of medical homes for children served by the Department of Social Services (DSS) who are covered by Medicaid. MassHealth plans to work with DSS to perform an assessment of the needs of the DSS children, and plan to enhance the primary care delivery system with elements of a medical home model for these at-risk Medicaid recipients under the state's Primary Care Clinician (PCC) Plan. MassHealth also plans to develop additional enhancements to its PCC Plan, based on the elements of a medical home, as part of a phased in approach to PCC Plan enhancement.	Medicaid agency is authorized to conduct a pilot and commissioner of health care finance and policy (which oversees Medicaid/SCHIP) is co-chairing the special commission	Chapter 305 of the Acts of 2008, sections 30, 44			PCCM, MCO	The commission must file the report of its findings and recommendations no later than April 1, 2009	Children served by DSS, later others	"...which at minimum shall include primary care practices with a multi-specialty team that provides patient-centered care coordination through the use of health information technology and chronic disease registries, across the patient's life-span and across all domains of the health care system and the patient's community."		Summit application http://www.mass.gov/legis/laws/seslaw08/sl080305.htm
Michigan	Michigan Primary Care Consortium (MPCC) created in 2006 to implement strategic plans to resolve barriers to improving patient care and sustaining primary care. Its vision includes a medical home for every patient in primary care.	Medicaid agency is a member of the MPCC			MPCC awarded a 2-year "Improving Performance in Practice" (MI-IPIP) grant through the American Board of Medical Specialties, funded by RWJF in 2007		MPCC created in 2006, Practices to begin working in MI-IPIP in 2008	MI-IPIP: adults with diabetes and children with asthma			Summit application http://www.mipcc.org/ http://ipip.aiag.org/

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Minnesota	Medicaid: Minnesota enacted legislation in 2007 that prompted the state to begin policy planning for Medical Home services provided to Medicaid enrollees. In 2008, the state enacted legislation extending the requirement to provide (and pay for) patient-centered medical homes to all payers. The standards are to be implemented in Medicaid (and other public coverage programs) in July 2009 and among commercial carriers in 2010. The State is working with provider and patient communities to develop specific criteria and certify providers who meet those criteria to provide comprehensive care coordination and care plan development	Medicaid/SCHIP agency is developing program	Minnesota Laws 2007 Ch. 147 Laws of 2008: CHAPTER 358/Article 2 - Health Care Homes			FFS and MCOs	Standards to be developed by July 2009, implemented for all payers by July 2010	Medicaid, then all Minnesotans	Requirements. In order to be designated a pilot project, health care professionals or clinics must demonstrate the ability to: (1) be the patient's first point of contact by telephone or other means, 24 hours per day, seven days a week; (2) provide or arrange for patients' comprehensive health care needs, including the ability to structure planned chronic disease visits and train and support the caregivers to effectively monitor and manage the person's health condition; (3) coordinate patients' care when care must be provided outside the medical home; (4) provide longitudinal care, not just episodic care, including meeting long-term and unique personal needs; and (5) systematically improve quality of care using, among other inputs, patient feedback.	Physician Nurse practitioner Physician's Assistant	Summit application Presentation at NASHP preconference http://www.health.state.mn.us/healthreform/hchomes.html
Missouri	Medicaid (MO HealthNet): Has been tasked by the legislature with developing health care homes for all MA enrollees to begin 7/08 and be in place by 7/11. They have already implemented the Chronic Care Improvement Program and plan to release an RFP to select new managed care plans in December 2008, and are considering how to incorporate requirements relevant to ensuring health care homes for all Medicaid and improving chronic care management. The 2007 legislation also created the HealthNet Oversight committee to oversee implementation of all aspects of the legislation, including those related to health care homes. Finally, in 2007, the state launched "CyberAccessSM, an electronic health record for all MO HealthNet participants that includes all paid claims data, an electronic plan of care, e-prescribing and real time prior authorization for medications and durable medical equipment."	Medicaid agency is administering program. Medicaid staffs the oversight committee and the director of the Department that oversees the Medicaid and SCHIP agency is a member of the committee	Missouri Continuing Health Improvement Act of 2007			MCO and FFS	Plan to have health care home for all Medicaid by July 2011. Some aspects are already in place as of October 2008.	Medicaid			Response to state scan survey http://www.dss.mo.gov/mhd/oversight/pdf/handout2008aug05.pdf http://www.dss.mo.gov/progoverview.pdf
New Hampshire	NH Multi-Payer Medical Home Project: a new workgroup created in January 2008 (as a result of Governor Lynch's New Hampshire Citizens Health Initiative (CHI)) with the purpose of developing a medical home pilot for NH. Private sector portion of pilot will begin January 2009; Medicaid pilot will begin July 2009. Both pilots will run 24 months. CHI has adopted the Joint Principles and will use NCQA's Physician Practice Connections Patient-Centered Medical Home Recognition Program standards.	Medicaid participating in collaborative and will establish pilot			■ $1.3 million/year of state's existing disease management budget will be shifted to the Medicaid pilot. ■1 FTE for Medicaid pilot from Office of Medicaid Business and Policy	FFS	Private sector pilot will begin January 2009; Medicaid pilot will begin July 2009. The state's MMIS will implement medical home designation capability in spring 2009	Private pilot will include all patients in 4-5 delivery systems. Medicaid portion of pilot will initially focus on the disabled population.	Joint Principles		http://www.steppingupnh.org/index.cfm?id=F698B064-FA56-9CE4-D58622FEAD5F6176 New Hampshire Medical Homes Summit state team application
North Carolina	Medicaid, in coordination with the office of rural health launched a PCCM program (Carolina ACCESS) in 1991. They required providers to form local networks to serve Medicaid enrollees. The Medicaid agency pays a PCCM fee to both the network and the primary care practice. In 1998, Community Care of North Carolina (CCNC) was formed to support the networks. It is sponsored by Medicaid and the office of rural health. CCNC features (1) medical and administrative committees that provide direction on care management activities; (2) Dedicated case managers to carry out population management activities; (3) Care management processes that apply both new and existing resources in meeting the needs of enrollees; and (4) Regular reporting and profiling of target initiatives that allow networks to monitor their progress in achieving target goals. They conduct quality improvement efforts in a variety of areas and are working to implement a physician incentive payment as well as expand to include people with disabilities and dual eligibles.	Medicaid sponsors CCNC and administers Carolina ACCESS, they also funded the HealthyStart initiative to support use of medical homes.		Section 1932	NC DHHS	PCCM	Started in 1990's, but expanded to include people with disability in 2007.	750,000 Medicaid enrollees	Carolina ACCESS is North Carolina's Medicaid managed care program. It provides you with a medical home and a primary care provider (PCP) who will coordinate your medical care. What is a medical home? A medical home: • offers the very best of care for you. The staff will know you and your medical history. They will coordinate your health care with other doctors who may need to treat you. • can be a doctor's office, a community clinic, or a local health department. • provides a PCP you can call for help when you need to. You no longer have to go to the emergency department when your problem does not threaten your life or risk your health without immediate treatment. • provides treatment and/or medical advice 24 hours a day, 7 days a week.	Health Clinics Federally Qualified Health Centers (FQHCs) Rural Health Centers (RHCs) Nurse Practitioners Nurse Midwives Physician Assistants Pediatricians General Practitioners Family Practitioners Internists Health Departments Hospital Outpatient Clinics Community Health Centers	http://www.dhhs.state.nc.us/dma/ca/carechandbook.pdf http://www.nchealthystart.org/outreach/medicalhome/index.html http://www.communitycarenc.com/ http://www.cms.hhs.gov/MedicaidDataSourcesGenInfo/Downloads/nationalsummreport06.pdf

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Oklahoma	Medicaid has operated a capitated PCCM program since the 1990s. However, the Medical Advisory Task Force (MAT) recommended the Oklahoma Health Care Authority (OHCA) modify the service delivery model to pure PCCM, while embracing the patient-centered medical home approach. This new model will be in place by January 2009. OHCA's primary goal is to guarantee the availability of a medical home with a primary care provider for all SoonerCare Choice members; that will (1) enhance patient choice and participation in health decisions; (2)assure all members receive all necessary preventive and primary care; (3) reduce inappropriate emergency department visits and hospitalizations; (4)realign payment incentives to improve cost effectiveness and quality; and (5) promote the use of health information.	Medicaid administers program		Medicaid/SCHIP 1115 waiver (SoonerCare)		PCCM	January 2009	Populations approved for 1115 managed care demonstration: pregnant women and infants under age 1; children 1-18; adults with children in TANF; ABD-TEFRA children; breast and cervical cancer prevention and treatment women.	Joint Principles	individual physicians, physician assistants and advanced nurse practitioners as contractors, as well as groups of practitioners. Specialties include family medicine, pediatrics, and OB/GYN.	http://www.ohca.state.ok.us/providers.aspx?id=8470&menu=74&parts=8482 SoonerCare health management http://www.commonwealthfund.org/innovations/innovations_show.htm?doc_id=691095 medial home summit application
Oregon	Under new legislation partner with consumers, providers, purchasers, and payers to provide every Oregonian with an integrated health home, (1) create and support interactive systems of care which connect health homes with community-based services, public health, behavioral health, oral health, and social services; (2) provide the health care workforce with support to transform practices into health homes; (3)develop and evaluate strategies to empower consumers to become more involved in their health; and (4) strengthen the role of the safety net in delivering services to vulnerable populations. This work builds on public and private sector efforts to pilot medical homes, including grant funds to be awarded by the Department of Human Services. Also, Oregon was awarded a Medicaid transformation grant to develop and build a health record bank to electronically store Medicaid clients' health information and make it available on a secure-web site. The Bank is designed to support multidisciplinary teams for coordinating care (sometimes referred to as the "Medical Home" model of care).	Medicaid is participating in these efforts and is the grantee for the transformation grant	The Healthy Oregon Act (2007); SB 562, 2007		CMS Transformation grant Round 2 (2007): $5,500,093 for the creation of the Health Record Bank of Oregon.	FFS, MCO	Recommendations to the Governor and Legislature by fall 2008, several pilots are already in place	All Oregonians, including Medicaid beneficiaries	Primary care medical home can generally be characterized as a primary care practice which provides the following to its patients: a continuous relationship with a physician; a multidisciplinary team that is collectively responsible for providing for a patient's longitudinal health needs and making appropriate referrals to other providers; coordination and integration with other providers, as well as public health and other community services, supported by health information technology; an expanded focus on quality and safety; and enhanced access through extended hours, open scheduling, and/or email or phone visits.	One of the Oregon Health Fund Board's recommendations to the state is to develop a set of standards that all payers would use to incentivize a medical home, or as the Board discusses, an "integrated health home" which allows for multiple models as "the home" – medical-focused practices or clinics, behavioral health focused practices or clinics, with the appropriate collaboration with other disciplines.	http://www.fcw.com/online/news/150410-1.html http://www.oregon.gov/OHPPR/docs/The_Medical_Home_Model_Final.pdf http://www.oregon.gov/DHS/hrb-oregon/project-info/hrb-proposal.pdf http://landru.leg.state.or.us/07reg/measures/sb0500.dir/sb0562.intro.html
Pennsylvania	Pennsylvania Chronic Care Commission developed a plan that combines the chronic care model and medical home. While Medicaid and SCHIP are not participating payers, the Secretaries of the Departments that administer these agencies participated in program design and contracted MCOs are participating. These pilots feature changes to reimbursement policies and support for practices (practice coaches, access to disease registry, etc.) to support practices in making changes.	Secretary of the agency that administers Medicaid and of the agency that administers SCHIP are members of the Commission, the Commission's report lists existing Medicaid programs that support Commission goals,	Executive Order			MCO	Plan completed in February 2008. implemented in one region as of October 2008	Those covered by participating payers, including Medicaid members of two Medicaid-contracted MCOs.	Joint principles combined with Chronic Care Model		Presentation by Michael Bailit http://www.rxforpa.com/assets/pdfs/ChronicCareCommissionReport.pdf
Rhode Island	Connect Care Choice serves adults with Medicaid coverage. Participants receive their health care at a participating Connect Care Choice primary care physician practice or 'medical home'. Participants have access to a nurse care manager to help coordinate health care needs and provide a connection to support services in the community. The PCCM network includes Federally Qualified Health Centers and group practices that meet "advanced medical home" standards. The payment to practices has three components: (1) Fee-for-service payment for services provided by the practice to members, with the agency paying participating providers more than other providers for some services. (2) A per member per month PCCM fee of either $5 or $10 based on the enhanced services a practice offers, such as electronic tracking of patient information or open scheduling. (3) An additional $30 per member per month to practices that have a nurse case manager to help manage the care of members who are at moderate to high risk.	Medicaid administers the program				PCCM	2007	Adult (21+) Medicaid beneficiaries with chronically illness or disability	As defined by NCQA's PPC tool	Federally Qualified Health Centers (FQHCs) as well as group practices that meet "NCQA advanced medical home" standards	http://www.dhs.state.ri.us/dhs/whatnew/ccc.htm http://www.dhs.state.ri.us/dhs/whatnew/rhp_comparison.pdf http://www.nashp.org/Files/shpbriefing_pcmhsavings.pdf

State Initiatives to Advance Medical Homes for Medicaid and SCHIP Participants

(Initiatives that meet criteria for inclusion in analysis)

State	Program/Agency	Relationship to Medicaid or SCHIP	State authority	Federal authority	Funding/ Resources	Delivery System: (FFS, PCCM, MCO)	Start date	Population targeted/ #'s reached	Medical Home definition	Medical home provider types	Source
Rhode Island	The Rhode Island Medicaid agency and the MCOs that contract with the agency are participating in a multi-stakeholder collaborative that is developing an all-payer demonstration project. The purpose of the project is to manage chronic illness more effectively by aligning physician incentives to provide medical home services. The collaborative is working with the Medicaid agency's external quality review organization, Quality Partners of Rhode Island, on this "Chronic Care Sustainability Initiative." In this demonstration, qualified medical homes will receive a per member per month fee, in addition to the usual fee-for-service.	Medicaid participated in the design of the initiative, Medicaid contracted health plans and Medicaid fee-for-service (i.e. Connect Care Choice) are participating in the pilot.			Current fee-for-service payments plus monthly $3 pmpm fee to each practice for enhanced PCMH services, plus cash to support Care Managers	MCO, PCCM	2008	will reach 25,000 "covered" lives, includes all patients served by participating practices except fee-for-service Medicare--will include high acuity fee-for-service Medicaid (Connect Care)	Joint principles, plan to use NCQA PPC tool, providers must qualify for 'level 1 within 9 months and 'level 2' within 18 months		Presentation by Chris Koller at NASHP preconference
South Carolina	Implemented a capitated Medicaid Managed Care program, one goal of which is to link patients with a medical home and health care provider. The program is now operating statewide.	Medicaid administers the program		Section 1932		MCO	March 2008		Accessible, comprehensive, coordinated, family-centered primary and preventive care. Patient access to a 'live voice' twenty-four hours a day, seven days a week. Patient education about preventive and primary health care, utilization of the medical home, and appropriate use of the emergency room.		http://www.dhhs.state.sc.us/dhhsnew/insidedhhs/Bureaus/BureauofHealthServicesandDeliverySystems/ManagedCare.asp
Texas	The Texas Health and Human Services Commission (HHSC) implemented STAR Health in March 2008. It is a designed to improve services and better coordinate care for children in foster care (almost all children in foster care are covered by Medicaid). Children in foster care will begin receiving services through the program in April 2008. Services are provided through a contract with Superior HealthPlan Network. One of the stated project components is "A medical home through a primary care doctor who coordinates care and promotes better preventive health practices."	HHSC administers Medicaid and the child welfare agency. They worked together to develop this program and the state uses federal Medicaid funding to pay for the services provided by the MCO	Foster care: SB6 Texas Legislature, 79th Regular Session.			Single MCO, Superior HealthPlan Network	April 2008	Children in foster care	"Every child will have a "medical home." That means all children in STAR Health will have their own doctor or clinic (primary care provider) to oversee and coordinate their care. That includes medical, dental, and vision care, as well as prescription drug and behavioral healthcare services for every child"	Pediatricians, General/Family Practice, Internal Medicine, OB/GYNs, Federally Qualified Health Centers, Health Clinics	http://www.texasappleseed.net/1HZ601!.pdf http://www.hhs.state.tx.us/medicaid/StarHealth.shtml
Vermont	Blueprint for Health Medical Home pilots: Blueprint, a comprehensive and statewide transformation process, was established in 2003. In July 2008, communities will pilot the Blueprint medical home model (incorporating Community Care Teams), with the ultimate goal of systems-level change by 2011.	Medicaid will participate	Blueprint for Health legislation and S.283 of 2008 legislative session. In 2007, lawmakers passed legislation (Act 71) that "enhanced" the Blueprint and authorized the creation of "medical homes" for the chronically ill.		State funds. Under legislation enacted in June, 2008, insurers in Vermont will pay a tax of .19 percent to establish HIT systems that will enable providers to perform such tasks as track their patients' care and progress, receive information on evidence-based care and identify patients who are at risk for additional conditions.		In 2007, lawmakers passed legislation (Act 71) that "enhanced" the Blueprint and authorized the creation of "medical homes" for the chronically ill.	"The 1500 most expensive and complicated adults"			http://www.ncsl.org/programs/health/shn/2008/sn519c.htm
Washington	The Medical Home Initiative is a series of public-private efforts supported by multiple state agencies and the legislature, and with leadership from the Governor's Office. Public and private stakeholders are working together to improve health outcomes by expanding access to primary care providers and medical homes. Medical homes for Medicaid beneficiaries are being developed and implemented in conjunction with current chronic care management programs. In addition to pilots for Medicaid beneficiaries, state employees, and others, the state has committed to conducting two collaboratives. • The 2008 Collaborative features learning sessions for providers focused on improving systems of care for patients with chronic diseases and for children with special health care needs via medical homes. • The 2009 Collaborative will focus on expanding availability of medical homes for adults and children, and study reimbursement approaches that support and promote medical homes. • A reimbursement study to be conducted in 2008 resulting in a report to the legislature.	Medicaid is conducting pilots, working with other stakeholders to develop the two collaboratives	Legislation enacted HB 2549 (Establishing a primary care collaborative) SB 5930 Blue Ribbon Commission SB 5093 Child Health Care			FFS, PCCM, and MCO	January 2008	First, adults and children who qualify for Medicaid due to age or disability, including those who receive SSI. Ultimately, stakeholders envision including all citizens of the state.	An approach to providing health care services in a high-quality, comprehensive, and cost cost-effective manner. The Washington State Department of Health describes core elements of a medical home as: o Compassionate and Culturally Effective o Coordinated and Comprehensive o Family-Centered o Accessible and Continuous Programs must be evidence-based, facilitate the use of information technology to improve quality of care, acknowledge the role of primary care providers and include financial and other supports to enable these providers to effectively carry out their role in chronic care management, and improve coordination of primary, acute, and long-term care for those clients with multiple chronic conditions.	Physicians, physician assistants, advanced registered nurse practitioners and mental health providers.	Medical Home Summit application and follow-up survey http://www.leg.wa.gov/pub/BillInfo/2007-08/Pdf/Bills/Session%20Law%202007/5930-S2.SL.pdf

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West Virginia	West Virginia is transforming its primary care system into the Medical Home model. A comprehensive strategy is evolving, facilitated by CMS Medicaid Transformation Grants, where the medical home is a fundamental design principle. The approach involves the establishment of a Health Improvement Institute with the major stakeholders at the table. The initial focus is on the Medicaid population and will expand to all West Virginians. The Institute had its third meeting in July 2008. There are four work groups, each developing focused strategies: one is focused on new models for provider engagement and training; a second on accelerating the adoption of health information technology; a third on measurement/reporting/reimbursement and the fourth on strategies to accelerate self-activation of the population. West Virginia is also developing a Learning Community of practices that will serve as the testing ground for pilots and demonstrations on differing approaches to reimbursement, use of incentives, pay for performance, adoption of electronic health information and member engagement.	Medicaid beneficiaries are the initial target population, the Medicaid agency is the grantee for the transformation grants, and the Secretary of Health and Human Resources chartered the Health Improvement Institute	Legislation is targeted for 2009		■Transformation grant #1: FY2007$1.95m FY2008$1.95 m ■Transformation grant #2 FY2007 $740k FY2008 $992k ■Transformation grant #3 FY2007 $832k FY 2008 $934k ■Transformation grant #4 FY 2007 $918k FY 2008 $1m ■Transformation grant #5 FY 2007 $2.1m FY 2008 $2.2m		Institute launched in 2008, transformation grants for 2007/2008	Medicaid, then all West Virginians	"Medical home" means a team approach to providing health care and care management. Whether involving a primary care provider, specialist or sub-specialist, care management includes the development of a plan of care, the determination of the outcomes desired, facilitation and navigation of the health care system, provision of follow-up and support for achieving the identified outcomes. The medical home maintains a centralized, comprehensive record of all health related services to provide continuity of care.		http://www.cms.hhs.gov/MedicaidTransGrants/Downloads/MTGAwardsCombined.pdf Summit application http://www.wvhealthimprovement.org/wvkms/index.htm
Wisconsin	Wisconsin has several activities that encompass PCMH principles: 1) the Governor expanded coverage through Medicaid and SCHIP program to nearly all children, with an additional waiver for childless adults scheduled to go into effect in January 2009; 2) the Milwaukee Health Care Partnership (a collaboration between 5 hospital systems, 4 FQHCs, Wisconsin Medicaid/DHFS, and the County DHHS) has advanced activity relating to health information exchange (which went live in March 2008), emergency room triage protocols, and scheduling non-emergent patients directly into a local federally-funded Health Center, to serve as their medical home; 3)Medicaid has been reorganized into the Division of Health Care Access and Accountability, which made sweeping changes to oversight and administration of HMO contracts, with special attention on care management, incentives to ensure patients are actively managed in a primary care home, and maintaining appropriate physician panels; 4) three of four Milwaukee Health Centers received a local grant to enhance case management to serve as medical homes.	Medicaid is administering some aspects of these programs and actively involved in others		1115 waiver	Transformation grant: FY 2007 $1.85 m FY 2008 $1.2 m	MCO and FFS	2008 for health care partnership; transformation grant for 2007	Medicaid beneficiaries, especially those served by community health centers	A medical home is an approach to providing health care services in a cost-effective manner. Accessible, family-centered, continuous, comprehensive, coordinated, compassionate, culturally effective.		http://www.whie.org/ Summit application http://www.govhealthit.com/print/4_18/communities/350397-1.html?type=pf
Wyoming	Medicaid in Wyoming is developing a "Total Health Record" that will include the three elements of pay for participation, Patient-Centered Medical Home, and a patient-centered, Web-based electronic health record. The overall goal of the EHR for Wyoming is to establish connectivity and interoperability for the Wyoming Department of Health Medicaid program and to establish efficient electronic information sharing through a web-based solution, which will provide access to individual health information from multiple systems.	Medicaid (EqualityCare) is administering the program					RFP released 2008	Medicaid participants	A Medical Home is a model that facilitates the partnership between a patient and their Primary Physician. Its characteristics include that each patient looks first to their primary care physician with whom they have a long term relationship, who will lead a team at the practice level that takes responsibility for coordination of care of the patient, and make sure it is integrated across all elements of today's health care system (office, hospital, nursing home and home health care). Quality and safety will be emphasized, and the implementation of an EHR statewide will help to make sure patients cannot "fall between the cracks".		http://wdh.state.wy.us/healthcarefin/index.html wdh.state.wy.us/Media.aspx?mediaId=2208 - http://www.acponline.org/meetings/chapter/wy-2008.pdf